

§ 423.859

Qualifying plan means a full-risk or limited-risk prescription drug plan, as defined in § 423.258, or an MA-PD plan described in section 1851(a)(2)(A)(i) of the Act, that provides required prescription drug coverage, as defined in § 423.100. An MA-PD plan must be open for enrollment and not operating under a capacity waiver to be counted as a qualifying plan. A PDP must not be operating under a restricted enrollment waiver, such as those that may be granted to special needs plans or employer group plans, in order to be counted as a qualifying plan in an area.

§ 423.859 Assuring access to a choice of coverage.

(a) *Choice of at least 2 qualifying plans in each area.* Each Part D eligible individual must have available a choice of enrollment in at least 2 qualifying plans (as defined in § 423.855) in the area in which the individual resides. This requirement is not satisfied if only one entity offers all the qualifying plans in the area. At least 1 of the 2 qualifying plans must be a prescription drug plan.

(b) *Fallback service area—(1) For coverage year.* Before the start of each coverage year CMS determines if Part D eligible individuals residing in a PDP region have access to a choice of enrollment in a minimum of 2 qualifying plans, as described in paragraph (a) of this section. If CMS determines that Part D eligible individuals in a PDP region, or some portion of the region, do not have available a choice of enrollment in a minimum of two qualified plans, CMS designates the region or portion of a region as a fallback service area. Each Part D eligible individual in a fallback service area is given the opportunity to enroll in a fallback prescription drug plan.

(2) *For mid-year changes.* If a contract with a qualifying plan is terminated in the middle of a contract year (as provided for in § 423.508, § 423.509, or § 423.510), CMS determines if Part D eligible individuals residing in the affected PDP region still have access to a choice of enrollment in a minimum of 2 qualifying plans, as described in paragraph (a) of this section. If CMS determines that Part D eligible individuals in a PDP region, or some portion of the region, no longer have available a

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choice of enrollment in a minimum of two qualifying plans, CMS designates the region or portion of a region as a fallback service area.

(c) *Access to coverage in the territories.* CMS may waive or modify the requirements of this part if—

(1) CMS determines that waiver or modification is necessary to secure access to qualified prescription drug coverage for Part D eligible individuals residing in a State other than the 50 States or the District of Columbia; or

(2) An entity seeking to become a prescription drug plan in an area such as a territory, other than the 50 States or the District of Columbia requests waiver or modification of any Part D requirement in order to provide qualified prescription drug coverage.

§ 423.863 Submission and approval of bids.

(a) *Submission of bids—(1) Solicitation of bids.* Separate from the risk bidding process under § 423.265, CMS solicits bids from eligible fallback entities for the offering in all fallback service areas in one or more PDP regions of a fallback prescription drug plan during the contract period specified in § 423.871(b).

(2) *Timing of bids.* CMS determines when to solicit bids for 2006 so that potential fallback prescription drug plans have enough time to prepare a bid. After that, bids are solicited on 3 year cycles, or annually thereafter as needed to replace contractors between contracting cycles.

(3) *Format of bid.* CMS specifies the form and manner in which fallback bids are submitted in separate guidance to bidders.

(b) *Negotiation and acceptance of bids—*

(1) *General rule.* Except as provided in this section, the provisions of § 423.272 apply for the approval or disapproval of fallback prescription drug plans. CMS enters into contracts under this paragraph with eligible fallback entities for the offering of approved fallback prescription drug plans in potential fallback service areas.

(2) *Flexibility in risk assumed and application of fallback prescription drug plan.* In order to ensure access in an area in accordance with § 423.859(a), CMS may approve limited risk plans

under § 423.272(c) for that area. If the access requirement is still not met after applying § 423.272(c), CMS provides for the offering of a fallback prescription drug plan in that area.

(3) *Limitation of 1 Plan for all fallback service areas in a PDP region.* All fallback service areas in any PDP region for a contract period must be served by the same fallback prescription drug plan.

(4) *Competitive procedures.* CMS uses competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5)) to enter into a contract under this paragraph. The provisions of section 1874A(d) of the Act apply to a contract under this section in the same manner as they apply to a contract under that section.

(5) *Timing of contracts.* CMS approves a fallback prescription drug plan for a PDP region in a manner so that, if there are any fallback service areas in the region for a year, the fallback prescription drug plan is offered at the same time as prescription drug plans are otherwise offered. In the event of mid-year changes and as required by § 423.859(b)(2), CMS approves a fallback prescription drug plan for a PDP region in a manner so that the fallback prescription drug plan is offered within 90 days of notice.

(6) *No national fallback prescription drug plan.* CMS may not enter into a contract with a single fallback entity for the offering of fallback prescription drug plans throughout the United States.

§ 423.867 Rules regarding premiums.

(a) *Monthly beneficiary premium.* Except as provided in § 423.286(d)(3) (relating to late enrollment penalty) and subject to subpart P (relating to low-income assistance), the monthly beneficiary premium under a fallback prescription drug plan must be uniform for all fallback service areas in a PDP region. It must equal 25.5 percent of CMS's estimate of the average monthly per capita actuarial cost, including administrative expenses, of providing coverage in the PDP region based on similar expenses of prescription drug plans that are not fallback prescription drug plans.

(b) *Special rule for collection of premiums in fallback prescription drug plans.* In the case of a fallback prescription drug plan, the provisions of § 423.293 (b) concerning payments of the late enrollment penalty to the PDP sponsor do not apply and the monthly beneficiary premium is collected in the manner specified in § 422.262(f)(1) of this chapter, or paid directly to the fallback entity by the beneficiary if there are either no benefits, or insufficient benefits available to be collected in the manner specified under § 422.262(f)(1) of this chapter. The amount of any premiums collected by the fallback entity is deducted from management fees due from CMS.

§ 423.871 Contract terms and conditions.

(a) *General.* Except as may be appropriate to carry out the requirements of this section, the terms and conditions of contracts with eligible fallback entities offering fallback prescription drug plans are the same as the terms and conditions of contracts at § 423.504 and § 423.505 for Part D plans.

(b) *Period of contract.* A contract with a fallback entity for fallback service areas for a PDP region is in effect for a period of 3 years. However, a fallback prescription drug plan may be offered for any year within the contract period for a particular area only if the area is a fallback service area for that year.

(c) *Entity not permitted to market or brand fallback prescription drug plans.* Notwithstanding any other provisions of this part, an eligible fallback entity with a contract under this part may not engage in any marketing or branding of a fallback prescription drug plan.

(d) *Performance measures.* CMS issues guidance establishing performance measures for fallback prescription drug plans based on the following:

(1) *Types of performance measures.* Performance measures include at least measures for each of the following:

(i) *Costs.* The entity contains costs to the Medicare Prescription Drug Account and to Part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity through mechanisms such as generic substitution and price discounts.